Senate Budget & Fiscal Review

Senator Wesley Chesbro, Chair

Subcommittee No. 3
on
Health, Human Services, Labor, & Veterans Affairs

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April 12th, 2004
1:30 PM
Room 4203

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Item	*Description*
4260	**Department of Health Services, Medi-Cal Program issues as follows:**

- Status of Past Year Cost Containment Items
- Administration's Medi-Cal Redesign Proposal
- Managed Care Expansion
- County Organized Health Care Systems
- Quality Assurance Fee for Managed Care
- Graduate Medical Education Funding
- Medi-Cal Anti-Fraud Proposals (various)
- Other issues as noted in agenda

PLEASE NOTE: **Only those items contained in this agenda will be discussed in the hearing. Issues will be discussed in the order as noted in the Agenda unless otherwise determined by the Chair.**

Issues pertaining to the DHS will be reviewed again at the Subcommittee's May 3rd and May 10th "OPEN" issues hearings, and again at the time of the Governor's May Revision. ***Please see the Senate File for dates and times of subsequent hearings***.

Testimony will be limited due to the volume of issues. Please be direct and brief in your oral comments so that others may have the opportunity to testify. Written testimony is also welcomed. Thank you for your consideration.

Item 4260--Department of Health Services, Medi-Cal Program *(Selected Issues)*

A. Background Summary of the Medi-Cal Program

Purpose: The federal Medicaid Program (called Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance. **It is at least three programs in one: (1) a source of traditional health insurance coverage for poor children and some of their parents, (2) a payer for a complex set of acute and long-term care services for the frail elderly and people with developmental disabilities and mental illness, and (3) a wrap-around coverage for low-income Medicare recipients.**

Who is Eligible and Summary of Medi-Cal Enrollment: Generally, Medi-Cal eligibles fall into **four categories of low-income people as follows: (1) aged, blind or disabled; (2) low-income families with children; (3) children only; and (4) pregnant women.** Men and women who are not elderly and do not have children or a disability ***cannot*** qualify for Medi-Cal no matter how low-income they are. **According to the DOF, Medi-Cal provides health insurance coverage to about 17 percent of Californians.**

Generally, Medi-Cal eligibility is based upon family relationship, family income level, asset limits, age, citizenship and California residency status. Other eligibility factors can include medical condition (such as pregnancy or medical emergency), share-of-cost payments (i.e., spending down to eligibility), and related factors that are germane to a particular eligibility category. States are required to include certain types of individuals or eligibility groups under their Medicaid state plans and they may include others—at the state's option.

Medi-Cal caseload is **anticipated to increase by about 220,000 in the budget year for a total of about 6.8 million average monthly eligibles. Of the total Medi-Cal eligibles about 45 percent, or 2.8 million people, are categorically-linked to Medi-Cal through enrollment in public cash grant assistance programs (i.e., SSI/SSP or CalWORKs).**

LAO Table
Major Medi-Cal Eligibility Categories
2003-04

	Maximum Monthly Income or Grant	Asset Limit Imposed?	Spend Down Allowed?	Enrollees (Thousands)	Annual Benefit Costs Per Person
Aged, Blind, or Disabled Persons					
Welfare (SSI/SSP)	$1,419	Yes		1301	$7,938
Medically needy	$9,54	Yes	Yes	247	$7,355
133 percent of poverty equivalent	$1,419	Yes	Yes		
Medically needy-long-term care	Special limits	Yes	Yes	64	
Families					
Welfare (CalWORKS)	$1,150	Yes		1479	$1,459
Section 1931(b)-only	$1,624	Yes		2605	$1,531
Medically needy	$1,190	Yes	Yes		
Children and Pregnant Women					
200 percent of poverty—pregnancy service and infants	$3,157			203	$3,488
133 percent of poverty—ages 1 through 5	$2,130			117	$1,260
100 percent of poverty—ages 6 through 18	$1,624			111	$1,005
Medically indigent—ages 6 through 18	$1,190	Yes	Yes	221	$1,329
Medically indigent adults—all services	$1,190	Yes	Yes	6	$12,001
Emergency Medical Services Only				822	$1,231

Background Summary (continued)

Summary of Overall Funding: The Governor proposes total expenditures of $31.2 billion ($11.6 billion General Fund) which reflects a General Fund increase of $1.6 billion, or 16.2 percent above the Budget Act of 2003. **The General Fund increase primarily reflects the costs of using one-time savings in 2003-04 from the accrual-to-cash accounting change, and the discontinuation of the enhanced federal financial participation provided in the federal Jobs and Growth Tax Relief Reconciliation Act of 2003 (**$655.4 million in General Fund required to backfill for federal funding loss)**.**

The budget proposes expenditures for 2003-04 (current year) and 2004-05 (budget year) are as follows:

(Figures Rounded) 2004-05 (Budget Year)	**Total Funds** (Dollars in thousands)	**General Fund** (Dollars in thousands)	**Federal Funds** (Dollars in thousands)	**Other Funds** (Dollars in thousand)s
Medical Care Services	$28,600,000	**$10,825,000**	$15,967,000	$1,807,000
County Administration	2,262,000	**630,500**	1,632,000	
Fiscal Intermediary	354,000	**113,000**	240,000	370
TOTAL	**$31,216,000**	**$11,569,000**	**$17,839,000**	**$1,808,000**
2003-04 (Current Year)				
Medical Care Services	$26,861,000	**$9,082,000**	$15,683,000	$2,095,500
County Administration	2,056,500	**592,000**	1,465,000	118
Fiscal Intermediary	297,000	**91,000**	205,000	424
TOTAL	**$29,214,500**	**$9,765,000**	**$17,353,000**	**$2,096,000**

As noted in the table below, the average cost per eligible for the aged, blind and disabled caseload (including long-term care) is much higher than the average cost per eligible for families and children on Medi-Cal. **As noted by the LAO, almost two-thirds of Medi-Cal spending is for the elderly and disabled, although they account for only about one-fourth of the total Medi-Cal caseload.**

DHS Table Medi-Cal Expenditures by Eligible Category	**Total Funds**	**General Fund**
2004-05 (Budget Year)		
Aged, Blind & Disabled	$16.892 billion	$8.446 billion
Families and Children	$5.838 billion	$2.919 billion
2003-04 (Current Year)		
Aged, Blind & Disabled	$17,097 billion	$8.548 billion
Families and Children	$5.742 billion	$2.871 billion

B. Discussion Items: Medi-Cal Program

1. Status of Cost Containment Actions From Prior Budgets

Background and Subcommittee Staff Comment: The state has an ongoing structural budget problem. The **Legislature has taken action to implement a variety of cost containment measures within the Medi-Cal Program over the past two years (i.e., the Budget Act of 2002 and the Budget Act of 2003) to assist in mitigating expenditures. These actions have required considerable deliberation and have been difficult choices to make.** The intent of most of these actions has been to reduce General Fund expenditures but maintain crucial health care services to those most in need—our children, frail elderly, individuals with developmental disabilities, individuals with severe mental illness, and low-income families who need access to health care.

Actions taken through the budget usually require a complex series of implementing steps, such as hiring and training staff to conduct audits, contracting with a manufacturer to purchase less costly medical products, and analyzing complex data to discern the best approaches to medical utilization controls and payment controls. **If implementation does not proceed efficiently and effectively, General Fund savings goals are not achieved and other actions, which can be more problematic to individuals in need, become necessary to fill the void and to balance a budget.**

Upon review of the Medi-Cal estimate over the past two years, it is evident that implementation of budget cost-containment actions has not been achieving anticipated savings amounts. Tens of millions of General Fund have been lost due to delayed implementation, unfilled positions, and missed opportunities to effectively deployment resources on projects. Here are some examples:

- ***Implement durable medical equipment contracting and laboratory contracting:*** In the Budget Act of 2002, the DHS was given positions to proceed with contracting in this area. It was assumed that implementation would begin as of July 2002 and that savings of $3.3 million General Fund would be achieved (this assumed savings would begin in the fourth quarter). No savings occurred. In the Budget Act of 2003, it was anticipated that contracting would begin as of July 2003 and that this action would achieve $14.3 million in General Fund savings. As of the Governor's January revised budget for 2003-04 (current year), an implementation date of April 2004 is now assumed with estimated savings of $916,450 (General Fund). For 2004-05, it is anticipated that $13.4 million General Fund will be obtained. **As such due to delays in implementation, the state lost about $13 million in General Fund savings in the current year.**
- ***Series of items regarding management of Medi-Cal drug expenditures.*** In the Budget Act of 2003 a series of actions were taken—implement a "step drug therapy" program, conduct more therapeutic drug category reviews on selected drugs, and collect on "aged" drug rebates. In total, these actions were to save about $16.4 million (General Fund) in 2003-04. However, all of these have been delay for many months and the current-year savings level is now slated to only be $3.4 million General Fund. The delays in implementing the step drug

therapy program and conducting more therapeutic drug category reviews is particularly disconcerting because implementation of these actions build in savings in future years and also would serve to potentially boost savings in the generic drug contracting area.

A related issue is generic drug contracting. In the Budget Act of 2002, implementation of generic drug contracting was to commence as of July 2002 and save $26.7 million General Fund. This was subsequently revised in the Governor's January 2002-03 revised budget to commence as of January 2003. It is now slated to commence as of January 1, 2004 for half-year savings of $13.4 million General Fund in 2003-04 and full year savings of $26.7 million (General Fund) in 2004-05.

- ***Implementation of a new methodology for payments to providers for anti-hemophilic blood factor product.*** In the Budget Act of 2003, this action was adopted for anticipated savings of $1.2 million General Fund for 2003-04. However, the Governor's January 2003-04 revised current-year budget reflects no savings because implementation has been delayed until October 2004 due to "system changes".

In some cases where estimated savings did not materialize, the DHS noted in their Medi-Cal estimate package that: "This savings estimate has been reduced due to late budget passage, the elimination of vacant positions, and the requirement that the department develop and receive approval on a reduction plan pursuant to Section 4.10 of the Budget Act of 2003." In addition, the Governor's hiring freeze and need to obtain "freeze exemptions" from the DOF in order to hire positions to commence with some work also was referenced.

It is recognized that a budget is an estimate, and estimates are revised as more accurate and timely data is gathered and analyzed. However, it is a different matter if an estimate is revised downward due to delays in effective implementation.

Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. How does the DHS establish priorities with limited resources? Can't staff be temporarily re-assigned when feasible to address policy changes that achieve cost containment?**
- **2. What steps can be taken to streamline implementation and effectuate timely policy changes?**

Budget Issue: What assurances can be provided by the DHS that anticipated savings will materialize through the implementation of budget actions designed to achieve cost containment?

2. Medi-Cal Redesign Proposal—Seeking Broad Authority for Waiver

Background: The **Governor proposes to seek a federal 1115 Research and Demonstration Waiver to completely restructure the existing Medi-Cal Program.** Several states, most notably Oregon and Utah, have recently obtained this form of federal waiver**. However, each state's waiver is highly unique because 1115 Waivers are research and demonstration efforts designed to provide states with broad authority and flexibility to test new ideas that warrant policy merit**. By definition, all federal waivers must be cost-beneficial (i.e., not result in higher expenditures) over the period of the waiver—usually five years—and then must be renewed with the federal government. All waivers must contain an evaluation component that addresses both policy and fiscal issues.

The Governor's proposed Waiver is presently a framework. The types of changes under consideration by the Administration represent fundamental changes to Medi-Cal and the most significant changes since the Medi-Cal commenced in 1966. The Governor's proposed Waiver *may* include all or any of the following components:

- Simplification by aligning Medi-Cal's eligibility standards and processes with CalWORKs and the SSI/SSP program;
- Development of a multi-tiered benefit/premium structure that provides comprehensive benefits to federally mandated populations and basic benefits to optional eligibles, with more comprehensive benefits available to those willing to pay premiums;
- Requiring co-payments for various services;
- Conform the basic Medi-Cal benefits package to that of private health plans, including making changes to mental health benefits provided under the EPSDT Program for children; and
- Expand Medi-Cal Managed Care to additional counties, review and reform managed care reimbursement policies and encourage the enrollment of the aged, blind and disabled into managed care.

No savings for 2004-05 are identified since only a framework of ideas is proposed at this time. However the Administration assumes savings of $800 million ($400 million General Fund) for 2005-06. No details on this cost calculation are available. The Administration states that this is a "place-holder" figure but that maximizing cost containment is a principal goal of the proposal.

California's Existing Federal Waivers are Extensive: California **presently has twenty federal Medicaid (Medi-Cal) waivers.** Most of these waivers are for uniquely defined populations and services, or provide services using different service delivery models. **These waivers enable the state to save money for services that would otherwise be delivered using a more expensive mechanism. Several of California's *key* waivers include the following:**

- **Family PACT.** This waiver provides pregnancy prevention services, including contraceptives, and sexually transmitted disease preventive services and education. Serves about 1.5 million women and men annually.

- **Los Angeles County.** This waiver allows Los Angeles County to restructure its public health delivery system and increase delivery of outpatient and preventative health care services.
- **County Organized Health Care Systems (COHS).** California has five COHS, including the Health Plan of San Mateo, Partnership Health Plan of California, Santa Barbara Health Initiative, Central Coast Alliance for Health, and Cal OPTIMA. Waivers—primarily to waive an individuals freedom of choice to select a provider—are used to operate each of these under Medi-Cal.
- **Selective Provider Contracting Program.** This waiver enables the state to selective contract with certain hospitals to provide inpatient Medi-Cal services to recipients. It is one of the state's longest operating waivers and has saved the state well over a billion dollars over the past dozen years or so.
- **Specialty Mental Health (Mental Health Managed Care).** This waiver enables the state to contract with County Mental Health Plans (County MHPs) to provide mental health services for enrollees with specified diagnoses requiring treatment by licensed mental health professionals. It is through this waiver that the counties operate and manage the state's Medi-Cal Mental Health Managed Care system.
- **Home & Community-Based Waiver for Individuals with Developmental Disabilities.** This waiver enables the state to provide home and community-based services to individuals with developmental disabilities who are Regional Center clients and reside in the community as an alternative to care provided in an Intermediate Care Facility for the Developmentally Disabled (ICF-DD). About 60,000 individuals are currently enrolled with this number increasing to 70,000 by the end of 2006.
- **Multipurpose Senior Services Program (MSSP).** This waiver provides home and community-based services to Medi-Cal recipients who are 65 years or over and are medically needy. This waiver enables these individuals to live in their home versus living in a nursing care facility.

Each of California's existing waivers, particularly those noted above, required considerable forethought, expert planning and analysis, communication with constituency groups, capacity building with providers, interaction with the Legislature and federal government, and carefully crafted implementation strategies to ensure the continuity of patient care. Most of these waivers required considerable time and concentrated work to phase-in—usually over a period of multiple years.

Status Update on Administration's Proposal and Stated Time Line: The Administration, in conjunction with assistance from the California HealthCare Foundation and The California Endowment, has been convening a series of workgroup meetings. **There are five workgroups which will meet a total of four times between march and April to discuss issues and offer comments. The five workgroups include the following:**

- Benefit Design and Cost Sharing;
- Program Eligibility and Simplification;
- Organized Service Delivery, including Managed Care;

- Aging and Disability Issues; and
- Financing

The CA Health and Human Services Agency states that it is also anticipated the workgroups will meet at least two additional times during the 1115 Waiver development phase (June through October 2004).

The Administration's proposed time table is as follows:

- Mid-March 2004—Start stakeholders meetings and continue throughout the process.
- May 2004—Waiver concept paper submitted to the Legislature.
- July 2004—Obtain budget trailer bill legislation to implement.
- October 2004—Submit waiver to federal Centers for Medicare and Medicaid (CMS).
- December 2004—CMS approval obtained.
- December 2004-June 2005—County and state system changes.
- July 2005 through June 2006—Phased in waiver implementation.

Governor's Proposed Budget: The budget proposes **an increase of $6 million ($2.2 million General Fund) within the DHS item in 2004-05 to (1)** hire 15 new state staff, **(2)** contract with a Mr. Charles Miller to assist the DHS in securing federal Waiver approval (a sole source contract?) at $250,000 ($125,000 General Funds), **(3)** contract with EDS and Delta Dental for staff support at $1.5 million (total funds), and **(4)** contract with EDS at $2.8 million ($700,000 General Fund) for fiscal intermediary-related computer system changes.

Subcommittee Staff Comment: The time table proposed by the Administration is very aggressive particularly given the complexities of modifying an entire program that services 6.8 million recipients, has a statewide network of thousands of various health care providers, and serves a diverse, medically-needy population. **Further, it is unknown at this time how many of the state's existing waivers will be incorporated into this very encompassing waiver.**

As specifics come forth from the Administration it will be imperative for the Legislature to thoroughly discuss the policy merits of the proposal and its short-term and long-term implications for providing health care to medically needy individuals. Further, the Legislature will need to maintain legislative authority over the program in order to preserve the integrity of the overall program and the services provided under it.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. Please describe the work group process and the proposed Waiver concept.**
- **2. Is the DHS proposing to consolidate some of state's existing Waivers into this proposed 1115 Waiver?**
- **3. Please describe the potential options affecting eligibility and benefits.**
- **4. Please provide an update on the proposed timeframes.**

Budget Issue: Does the Subcommittee want to **hold this issue OPEN pending further discussions with the work groups and receipt of the May Revision?**

3. Potential Expansion of Medi-Cal Managed Care

Background--Overall: The DHS **is the largest purchaser of managed health care services in California with over 3.2 million enrollees in contracting health plans.** The state's Managed Care Program now covers **22 counties through three types of contract models--Two-Plan Managed Care, Geographic Managed Care, and the County Organized Health Systems (COHS). The state has federal approval to operation the Medi-Cal Managed Care Program under State Medicaid Plan authority.**

For people with disabilities, enrollment is *mandatory* in the County Organized Health Systems, and *voluntary* in the Two Plan model and Geographic Managed Care model. About 161,000 individuals with disabilities are enrolled in a Medi-Cal managed care (2002 figure) plan.

In addition, **certain services are "carved-out"** of the Two Plan model and the Geographic Managed Care model, as well as some of the COHS's. **Most notably, the California Children's Services Program is "carved out", except for in selected counties which operate under the COHS model.**

Background--Two Plan Model (in 12 Counties): The Two Plan model was designed in the late 1990's. **The basic premise of this model is that CalWORKS recipients (women and children) are automatically enrolled (mandatory enrollment) in either a public health plan (i.e., Local Initiative) or a commercial HMO. Other Medi-Cal members, such as aged, blind and disabled, other children and families, can voluntarily enroll if they so choose. About 74 percent of all Medi-Cal managed care enrollees in the state are enrolled in this model.**

Plan Name	County	June 2003 Enrollment
Alameda Alliance for Health (LI)	Alameda	73,840
Blue Cross of California	Alameda, Contra Costa, Fresno, Kern, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare	360,760
Contra Costa Health Plan (LI)	Contra Costa	41,909
Health Net	Fresno, Los Angeles, Tulare	579,588
Kern Health Systems (LI)	Kern	69,432
La Care Health Plan (LI)	Los Angeles	824,271
Inland Empire Health Plan (LI)	Riverside, San Bernardino	232,318
Molina Healthcare of California	Riverside, San Bernardino	91,702
San Francisco Health Plan (LI)	San Francisco	28,796
Health Plan of San Joaquin (LI)	San Joaquin	56,046
Santa Clara Family Health Plan (LI)	Santa Clara	66,812
Two Plan Model Total		**2,425,474**

Background—Geographic Managed Care (in Two Counties): The Geographic Managed Care model was first implemented in Sacramento in 1994 and then in San Diego County in 1998. In this model, enrollees can select from multiple HMOs. The commercial HMOs negotiate capitation rates directly with the state based on the geographic area they plan to cover. Only CalWORKS recipients are required to enroll in the plans. All other Medi-Cal recipients may enroll on a voluntary basis. Sacramento and San Diego counties contract with nine health plans that serve about 10.6 percent of all Medi-Cal managed care enrollees in California.

Plan Name	County	June 2003 Enrollment
Blue Cross of California	Sacramento and San Diego	92,173
Community Health Group	San Diego	66,086
Health Net	Sacramento and San Diego	39,558
Kaiser Foundation Health Plan	Sacramento and San Diego	29,049
Molina Healthcare of California	Sacramento	20,208
Sharp Health Plan	San Diego	50,238
Universal Care	San Diego	12,810
UC San Diego Healthcare	San Diego	13,344
Western Health Advantage	Sacramento	15,713
TOTAL		**339,179**

Background—County Organized Health Systems (Eight Counties): **Under this model, a county arranges for the provision of medical services, utilization control, and claims administration for *all* Medi-Cal recipients. Since COHS serve all Medi-Cal recipients, including higher cost aged, blind and disabled individuals, COHS receive higher capitation rates on average than health plans under the other Medi-Cal managed care system models (i.e., Two Plan Model and the Geographic model).**

It should be noted that the capitation rates for COHS are confidential since the California Medical Assistance Commission (CMAC) negotiates contracts with each county plan and there is only one plan for all Medi-Cal recipients in said county. **Only those individuals on the CMAC, including the DOF and DHS, know the capitation rates.**

As noted in the chart below, **about 540,000 Medi-Cal recipients** receive care from these plans. This accounts for about 16 percent of Medi-Cal managed care enrollees and about nine percent of all Medi-Cal enrollees. **It should be noted that federal law mandates that only 10 percent of all Medi-Cal enrollees can participate in the COHS model. As such, the state is close to meeting this enrollment limit.**

Plan Name	County	June 2003 Enrollment
CalOptima	Orange	281,839
Central Coast Alliance for Health	Monterey, Santa Cruz	84,363
Partnership Health Plan	Napa, Solano, Yolo	77,704
Health Plan of San Mateo	San Mateo	45,742
Santa Barbara Regional Health Authority	Santa Barbara	50,276
TOTAL		**539,924**

Background—DHS Tracking of Managed Care Contracts: The DHS Medical Review Branch conducts periodic medical reviews of health plans contracted with the DHS. The reviews are designed to assess compliance with the terms of the contract, assist with monitoring overall compliance, and identify areas of deficiency. The essence of the review is to determine whether the plan has the capacity, organization, and structure to fulfill its obligation to both the state and Medi-Cal enrollees.

The DHS Audits and Investigations (A & I) Division reviews contract compliance in the areas of utilization management, continuity of care, availability and accessibility, members' rights, and administrative and organizational capacity. Beginning in 2002, contract compliance in the area of quality management was incorporated into the audit program. The A & I Division also coordinates audits with the Department of Managed Health Care (DMHC) to perform joint reviews where applicable. A & I reviews the plans (about 40) on a tri-annual basis.

Background—DHS Use of HEDIS Data for Quality Improvement: Health Employer Data Information System (HEDIS) measures are used by the DHS to form the basis of their "external accountability set"—a set of standardized performance measures selected by the DHS that focus on services provided to children and women of child-bearing age. The DHS states that plan-specific and systemic-level results are compared to Medicaid rates in other states, national benchmarks, and rates for commercial populations. This information is not only used to establish standards for minimum performance, but more importantly, to identify priorities for quality improvement. Specifically, the DHS notes that this data is currently being used to focus on adolescent health care improvement and will also be used to address issues regarding asthma care, diabetes care, and early child development services in Medi-Cal Managed Care.

Background—DHS External Quality Review Organization (EQRO): As required by federal law, the DHS must have independent reviews done of the Managed Care Program. The DHS has contracted with Delmarva Foundation for Medical Care to be the state's EQRO contractor (as of December 2003). According to the DHS, this contractor has completed 10 of 22 Health Employer Data Information Set (HEDIS) compliance audits and has initiated other required CAHPS surveys (for adults and children) for all 22 plans. The DHS also states that this contractor has provided consultation on design of other statewide quality improvement indicators.

Background--DHS to Start "Rewarding" Managed Care Plans: The DHS has partnered with the California Healthcare Foundation to conduct a research project intended to provide options and recommendations **to incorporate a "rewarding results" methodology based on a plan performance into the department's "default" assignment methodology (when a Medi-Cal recipient does not choose a health care plan within a specified timeframe, they are placed into one). The DHS states that the objective of this project is to create a new assignment methodology that will reward Medi-Cal managed care health plans that perform at a higher level relative to their competitors in Two Plan model and Geographic Managed Care counties.**

Quality measures being considered include Health Employer Information Data Set (HEDIS) data, a requirement that each plan undertake an annual process of setting improvement goals and

improving quality through a process referred to as "internal quality improvement projects" and a measure associated with the submission of encounter data.

An advisory workgroup consisting of representatives from the Local Initiatives, commercial health plans, safety net providers, consumer organizations and DHS staff has been convening to discuss and develop this process.

Governor's Proposed Budget: The DHS proposes **to expand enrollment in Medi-Cal Managed Care for parents and children in an additional 14 counties that current operate under the Medi-Cal fee-for-service system. Based on DHS estimates, this expansion would transition about 414,000 Medi-Cal recipients into managed care.**

The potential geographic areas **include the following 20 counties:**

• Butte	El Dorado	Humboldt	Imperial	Kings
• Lake	Madera	Mendocino	Merced	Nevada
• Placer	San Benito	San Luis Obispo	Shasta	Siskiyou
• Sonoma	Sutter	Tehema	Ventura	Yuba

The DHS notes that most of these 20 counties have service areas that have never had managed care in their counties, and that providers and hospitals may be reluctant to participate. As such, a "county cluster" approach may be used whereby three to five counties (or more) would be clustered in an effort to ensure fiscal viability for the contracting health plan.

The budget requests to increase DHS staff by five positions to implement this expansion at a cost of $400,000 ($200,000 General Fund), as well as $250,000 ($126,000 General Fund) in additional funding for a state contractor that enrolls Medi-Cal recipients in managed care plans (i.e., Health Plans Option contractor).

No local assistance savings are assumed for 2004-05 due to the time needed to develop a plan as discussed further below. However, the DHS assumes savings of $16 million ($8 million General Fund) for 2005-06 as implementation is phased-in. Annual savings of $33 million ($16.5 million General Fund) are anticipated in 2006-07.

The proposed savings are based on the assumption that the state will pay capitation rates to health plans that are equivalent to 95 percent of the Medi-Cal fee-for-service rate.

This geographic expansion would require federal approval of the state's plan (i.e., State Plan Amendment required), the execution of contracts with additional managed care health plans, and changes to existing enrollment efforts. No federal waiver would be required for a geographic expansion

The DHS states that geographic expansions could include amendments to current contracts to add additional service areas. This process would require health plans to obtain a Knox Keene license modification by working with both the Department of Managed Health Care (DMHC) and the DHS**. Geographic expansions could also occur through a competitive procurement. If a competitive procurement is done, the DHS states that implementation of a new contract would take no less than one year to execute.**

The DHS notes that the selection of geographic areas for expansion would involve the analysis of various essential considerations such as follows:

- Size of the mandatory Medi-Cal population;
- Interest *and* capacity of health plans to serve the area;
- Affect on other funding sources, particularly hospital funding sources such as the federal funds received through SB 1255 supplemental payments (these supplemental payment programs are not available for managed care services, only hospital inpatient services);
- Protection of traditional and safety net providers;
- Changes to the state's overall Health Care Options process whereby individuals select their managed care plan, including the development of new enrollment packets, training of county eligibility service representatives, developing enrollment presentations and related items;
- Analysis of how and where Medi-Cal recipients access services (i.e., across county lines, going to regional specialty centers, access to transportation corridors);
- Development of new contracting rates which may involve negotiation of rates through the California Medical Assistance Commission (CMAC); and
- Cost-benefit analysis to discern potential savings.

Legislative Analyst's Office Comment and Recommendation: In her Analysis, the LAO states that while they believe expanding managed care warrants consideration, they do have two concerns with the proposal as follows:

- They believe that only two of the requested five positions will be needed in 2004-05. The other three positions would not be needed until 2005-06 since it is a phased-in proposal. **Therefore, the LAO recommends to delete three positions and $200,000 ($100,000 General Fund).**
- They believe the state could achieve savings on the costs of the enrollment contractor (health plan choice options) by allowing new enrollees who have already decided on a health plan to enroll in that plan at the time they apply for Medi-Cal benefits. **Such a change would reduce the contractor's mailing and enrollment processing costs and expedite the enrollment of the Medi-Cal recipient into the Managed Health Care plan. Though the LAO did not provide an exact estimate, they contend that savings of a few million General Fund could be achieved.**

Subcommittee Staff Comment and Recommendation: Expansion of Medi-Cal Managed Care into additional geographic areas has merit from both a fiscal and policy standpoint. This expansion should continue the mandatory enrollment of CalWORKs enrollees, and the voluntary enrollment of aged, blind and disabled. **Any mandatory enrollment of aged, blind and disabled individuals would require substantially more research, data analysis, quality assurances/improvements, health care service network expansions, and substantial recipient participation in designing a workable and meaningful program.**

It is recommended to direct the DHS to provide the Subcommittee with a more comprehensive proposal—including a more definitive work plan—as to how a proposed geographic expansion can be rolled out successfully for both Medi-Cal recipients and the

potentially contracting health care plans. It is suggested for the DHS to provide this to the Subcommittee prior to the May Revision.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. DHS, Please provide a brief update on existing Managed Care Program activities.**
- **2. DHS, Please describe the budget proposal.**
- **3. DHS,** Is the intent of the proposal to continue to have a voluntary enrollment of the aged, blind and disabled?
- **4.** DHS, **Would mandatory enrollment of aged, blind and disabled individuals into Managed Care require a federal Waiver? Does the DHS have existing authority to request such a Waiver on its own, without the approval of the Legislature?**
- **5.** Are there any on-going efforts to encourage their enrollment without going to a mandatory enrollment?
- **6.** DHS, What is the Administration's perspective on continuing the carve out for the California Children's Services (CCS) Program?
- **7. DHS,** How may you collaborate with both the DMHC as well as the CMAC on proceeding with implementation?
- **8. DHS,** What mechanisms will be used to coordinate efforts with advocacy groups and the contracting health plans?

Budget Issue: Does the Subcommittee want to provide additional resources for the DHS to geographically expand Medi-Cal Managed Care?

4. County Organized Health Systems (COHS)—Fiscal Problems Place State At Risk

Background—What Are COHS: The COHS model, the oldest of the three models used in California, was first implemented in 1982 in Santa Barbara and San Mateo counties. **Under this model, a county arranges for the provision of medical services, utilization control, and claims administration for *all* Medi-Cal recipients.**

Since COHS serve all Medi-Cal recipients, including higher cost aged, blind and disabled individuals, COHS receive higher capitation rates on average than health plans under the other Medi-Cal managed care system models (i.e., Two Plan Model and the Geographic model). COHS provide a broad range of covered services, including physician, hospital and pharmacy, and also provide some services not covered by the other Medi-Cal Managed Care plans—such as the nursing facility room and board benefit.

It should be noted that the capitation rates for COHS are confidential since the California Medical Assistance Commission (CMAC) negotiates contracts with each county plan and there is only one plan for all Medi-Cal recipients in said county. **Only those individuals on the CMAC, including the DOF and DHS, know the capitation rates.**

As noted in the chart below, about 540,000 Medi-Cal recipients receive care from these plans. This accounts for about 16 percent of Medi-Cal managed care enrollees and about nine percent of all Medi-Cal enrollees. It should be noted that federal law mandates that only 10 percent of all Medi-Cal enrollees can participate in the COHS model. As such, the state is close to meeting this enrollment limit.

Plan Name	County	June 2003 Enrollment
CalOptima	Orange	281,839
Central Coast Alliance for Health	Monterey, Santa Cruz	84,363
Partnership Health Plan	Napa, Solano, Yolo	77,704
Health Plan of San Mateo	San Mateo	45,742
Santa Barbara Regional Health Authority	Santa Barbara	50,276
TOTAL		**539,924**

The COHS plans are subject to licensure under the Knox-Keene Health Care Service Plan Act by the Department of Managed Health Care (DMHC). As such, they are obligated to meet certain state requirements meant to ensure financial stability and solvency in order to continue in operation. **Generally, these requirements obligate a health plan to demonstrate that it can achieve a positive cash flow from its operations and can show fiscal soundness by assuming a full financial risk during its history of operation. If these requirements are not met, DMHC can conduct a detailed examination of the health plan and recommend steps that may be taken to ensure the plan's operation.**

Background—Rate Adjustments: From **1985 through 2000, the state's budget had** routinely included additional funding for all managed care plans, including COHS' either annually or every two years. Rate increases were supported by an actuarial analysis as performed by the DHS actuaries. **Typically, the CMAC would negotiate a rate increase for COHS contractors with the exception of Santa Barbara (DHS negotiated this directly), somewhere below the actuarial limit, which traditionally had been calculated under the Medi-Cal Fee-For-Service equivalent.**

Beginning in 2001-02 as a result of the budget deficit, rates were frozen and no funding for rate increases were provided for Managed Care plans, except for San Mateo and Santa Barbara. Rate increases for these two COHS plans were provided as a result of their deteriorating financial conditions. **In 2002-03 no rate increases were provided, and in 2003-04 a rate reduction of five percent was taken. The rate decrease is to occur with each plans next rate determination (As discussed in the March 8, 2004 Subcommittee hearing, the court action does not affect this decrease.).**

The Governor's proposed 2004-05 budget assumes another 10 percent rate decrease. In addition, a Quality Assurance Fee is proposed *(discussed later in this agenda)* that would provide a three percent rate increase to all Medi-Cal Managed Care Plans, including COHS. Implementation of this increase is dependent on federal approval.

Significant Fiscal Solvency Concerns: To-date, **all of the COHS have expressed concerns regarding the tenuous nature of their financial viability, particularly San Mateo, due to the low level of capitation rates. This is particularly true since they all provide services to their aged, blind and disabled populations as well.**

According to the DHS, projected dates (as reported by the plans) when "tangible net equity" (the key measure of fiscal solvency) will fall below standard requirements are as follows:

- Health Plan of San Mateo — August, 2004
- Santa Barbara Regional Health Authority — October 2004
- Central Coast Alliance for Health — December 2004
- Partnership Health Plan of California — June 2005
- Cal Optima — July 2005

When plan reserves decline to the tangible net equity minimum, the plan's ability to remain viable become a concern to regulators (DHS and DMHC) and COHS Boards must consider that insolvency may be imminent. Given the projected dates as noted above, the COHS financial situation is alarming.

Governor's Proposed Budget: The Governor's budget assumes that **(1)** COHS rates will be reduced by another 10 percent, and **(2)** the Health Plan of San Mateo (San Mateo) which provides services to about 50,000 Medi-Cal recipients will close its operations as of June 30, 2004, and revert to Medi-Cal fee-for-service as of July 1, 2004. **Based on an estimate provided**

by the DHS, the budget assumes an increase of about $10 million (General Fund) in the Medi-Cal Fee-for-Service base due to the projected termination of San Mateo.

Potential Option to Use Intergovernmental Transfer Funds: Voluntary intergovernmental transfer mechanisms are currently being used by California to draw down additional federal matching funds for use in the Medi-Cal Program without expenditure of state General Fund support. Specifically this is done under the state's SB 1255 Supplemental Payment Program accessed by certain hospitals. This intergovernmental transfer mechanism is limited by the amount of savings the state is able to achieve through its Selective Provider Contracting Program (whereby the CMAC contracts with certain hospitals for Medi-Cal inpatient days). The federal funds saved by hospital contracting are then allocated back to hospitals for supplemental funding. Due to federal "upper payment limits" ("OBRA" limits), some hospitals are limited on the amount of federal supplemental funding that they can receive.

The Administration has been having discussions with interested parties on the concept of using a similar intergovernmental transfer mechanism for COHS. Key aspects of this discussion have been as follows:

- **What would the source of the funds for the intergovernmental transfer be?**
- **Would federal approval be provided for such a mechanism for COHS?**
- **Would there be any upper payment issues that hospitals or the state would encounter?**

Legislative Analyst's Office Recommendation: In her Analysis, **the LAO recommends for the Legislature to reject the Administration's proposal to budget for the phase-out of San Mateo and to direct the DHS to explore alternatives that would permit it to remain in operation. In addition, the LAO suggests for the Legislature to consider several options** to address the financial problems experienced by the COHS in order to avoid an increase in General Fund costs and other serious consequences of their loss for Medi-Cal recipients.

Subcommittee Request and Questions: The Subcommittee is requesting the DHS and LAO to respond to the following questions:

- **1. DHS,** Please provide your perspective on the present fiscal situation of the COHS.
- **2. DHS, Does the state save money by contracting with COHS?**
- **3. DHS, What is the viability of utilizing an intergovernmental transfer for COHS? What would need to occur for implementation?**
- **4. DHS, Are there any other on-going discussions regarding ways to facilitate the fiscal viability of COHS?**
- **5. LAO, Please discuss your analysis.**

Budget Issue: Does the Subcommittee want to (1) adopt the LAO recommendation, and (2) direct the DHS to report back regarding options for assisting COHS to achieve fiscal stability (since it is in the state's interest to do so)?

5. Quality Assessment Fee for Managed Care Plans *(See Hand Out)*

Background: California utilizes several Medi-Cal Managed Care models for the delivery of health care services, including County Organized Health Care Systems (COHS), the Two Plan model (local initiatives and commercial HMOs), and Geographic Managed Care. **The DHS presently contracts with 31 health plans, many of which are considered *non-public* agencies.**

Under both state and federal requirements, the capitation rates paid under a managed care model must be below the fee-for-service cost equivalent. The rates paid to Medi-Cal Managed Care plans were frozen for the past two years and in the current year (2003-04) a five percent reduction is being enacted as of January 1, 2004.

Under the authority of the Social Security Act, Title 19, Section 1903(w)(7)(A), the state may impose a "quality assessment fee" on managed care contracts providing services under the Medicaid Program (Medi-Cal in California). **This mechanism can be used to then draw down additional federal funds.**

Budget Act of 2003: The Budget Act of 2003, and accompanying trailer bill language, assumed implementation of a "quality assessment fee" for Medi-Cal Managed Care plans and savings of $75 million (General Fund) from this effort. **However implementation issues arose in discussions with the federal Center for Medicare and Medicaid (CMS) as well as with some of the plans.**

Governor's Proposed Budget: The Governor proposes to implement a quality improvement assessment fee on Managed Care plans as of July 1, 2004 in the same manner as approved by the Legislature last year. **The net affect of this proposal would be to increase the rates paid to Medi-Cal Managed Care plans by about three percent and to save $75 million in General Fund support.**

Under the proposal the DHS would assess a quality assurance **fee of 6 percent** on all Medi-Cal Managed Care plans (Two Plan model, Geographic Managed Care and COHS). **The amount actual paid by each plan would vary, depending on their gross Medi-Cal revenue.**

The quality assessment fee would then be used to (1) obtain increased federal funds to provide a rate adjustment for Medical Managed Care plans, and (2) obtain increased funds to offset about $75 million in General Fund support.

Based upon information provided by the DHS, the fiscal arrangement would be as follows:

- 6 percent fee paid by Managed Care plans =$300 million in revenues
- State obtains a federal match on the fee paid by the plans =$300 million (federal funds)
- **State provides plans with rate adjustment** =$450 million ($225 million GF)
    - Net Increase to Managed Care plans =$150 million
    - Net savings to the General Fund =$75 million (net gain of 25% of fee)

The DHS will need to modify the state's existing Medi-Cal "Upper Payment Level" in order to make these funds available to the plans. The DHS would then distribute the "Upper Payment Level" amount to the various Two-Plan Model entities based on the existing DHS rate model that recognizes the cost of providing services in the county, and the plans acuity mix. For Geographic Managed Care Organizations and County Organized Health Care Systems (COHS), the California Medical Assistance Commission (CMAC) would allocate the funds through their existing contract process. In addition, the AIDS Health Care Foundation (as a primary care case management entity) would also be included in the quality assessment fee process.

Subcommittee Staff Comment: This proposal has both fiscal and policy merit. At the time of the release of this agenda, the only unresolved issues primarily pertained to trailer bill language.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **briefly describe** the proposal to implement a quality assessment fee for Medi-Cal Managed Care plans.
- **2.** Please explain **any unresolved issues regarding approval by the federal CMS or implementation issues which the Managed Care plans may still have.**
- **3 Has consensus been reached on issues regarding the trailer bill language?**

Budget Issue: Does the Subcommittee want to adopt or modify the Governor's quality assessment fee proposal on Managed Care plans?

6. Graduate Medical Education Funding—Eliminate Sunset

Background: The Omnibus Health Trailer Bill to the Budget Act of 1997-- SB 391 (Solis)-- established a method to help fund some graduate medical education costs through the Medi-Cal Program by leveraging voluntary transfers from public entities to obtain federal matching funds. A two-year sunset clause was inserted into the legislation at the request of the Administration. **Since this time, the program has been continually extended for either one or two year increments through budget trailer bill legislation.**

Similar programs in many states have been operating for many years. **California's program includes public teaching hospitals, children's teaching hospitals and major (non-University) teaching hospitals. The purpose of the program is to assist teaching hospitals with services relating to inpatient clinical teaching and medical education activities that are provided to Medi-Cal recipients. The matching non-federal funds are provided by public transferring entities, such as the University of California.**

Governor's Proposed Budget: The budget proposes **expenditures of $66.2 million (federal funds) for the teaching hospitals.** These funds will serve as the federal match to the non-

federal funds provided by the transferring entities. No General Fund moneys are associated with this proposal, nor has there ever been any associated with this discretionary program.

Subcommittee Staff Comment and Recommendation: The existing statute is slated **to expire as of June 30, 2005. As such it is recommended to approve the funding level contained in the Governor's proposed budget and to adopt trailer bill language to eliminate the sunset clause.** The program has been on-going since 1997 and does not affect the General Fund. If the transferring entities cannot provide funding, then no federal match is provided. The state is under no obligation to provide any funding what so ever.

Budget Issue: Does the Subcommittee **want to approve (1) the $66.2 million (federal funds) for the program as budgeted, and (2) eliminate the sunset to continue the Graduate Medical Education Program?**

7. Oversight of Electronic Data System (EDS) Contract with the DHS for Medi-Cal

Background: The state contracts with Electronic Data Systems (EDS) to perform the fiscal intermediary functions for the Medi-Cal Program, including claims processing services. **According to the LAO, state payments to EDS have risen about 23 percent a year during each of the last five years. Total payments to EDS are expected to be $232 million ($69 million General Fund) in 2004-05.**

Department of Finance, Office of State Audits & Evaluations—June 2003 Audit Findings: The DOF conducted an audit of the EDS contract last year because of concerns about the growing scope, size, complexity, and cost of the California Medicare/Medi-Cal Information Systems (MMIS)—the information technology system maintained and operated by the EDS to carry out its fiscal intermediary functions.

The DOF audit found weaknesses in DHS' oversight of the EDS contract, including the following key findings:

- ***Lack of Oversight:*** The DHS has no internal audit function to ensure that the EDS is complying with the terms of the contract and that the MMIS is operating as intended.
- ***Expenditure Information Not Provided:*** DOF budget staff were not provided timely or adequate information about expenditures being made for modifications (changes) authorized by the DHS for the MMIS. The DHS did not specifically track the cost to the state of these changes and therefore, the state had no method for determining whether these modifications were indeed cost-effective.
- ***No Payment Resolution Process:*** In the event the EDS disagreed with the amount paid to it by the state for its services, there were no procedures in place to resolve disputes with the contractor.
- ***State Information Technology Processes Sidestepped:*** The DHS incorporated information technology systems with little connection to the Medi-Cal Program into EDS' Medi-Cal contract to sidestep normal information technology development and procurement procedures. The DHS also circumvented the competitive procurement process without explicitly obtaining an exemption, making it difficult to ensure that that state received the best value for the development of these systems.

DHS to Provide "Information Systems Plan" (ISP) to DOF: According to the DOF, the DHS has been directed to provide an Information Systems Plan (ISP) to them by no later than June 30, 2004. According to the Administration, this ISP document is to provide a planned approach in implementing information systems projects within the Medi-Cal Fiscal Intermediary contract and determine the appropriateness of using the Fiscal Intermediary contract to implement information technology projects.

Specifically, the ISP is to address the current status of the Medi-Cal information management system as a whole and any concerns or issues common with most large systems. The ISP will also include information technology "system development notices" that are expected to be implemented in the upcoming year, as well as using the Fiscal Intermediary contract to develop non-Medi-Cal information system technology projects.

The DOF notes that the DHS will be required to provide the following information regarding any enhancement to the Medi-Cal system:

- Description of the project, including its benefits and impact on the overall system
- Costs and funding source
- How the project meets the DHS' business goals
- Justification for inclusion in the Fiscal Intermediary contract
- Project priority

Legislative Analyst's Office Recommendation: In her Analysis, the LAO notes that the state is at risk for overpaying EDS for Medi-Cal Program activities. Accordingly, the LAO recommends for the **Legislature to adopt Supplemental Reporting Language** directing the DHS to develop and submit a corrective action plan to the DOF and the Legislature, **and submit reports to both entities every six months commencing July 1, 2004. This language is as follows:**

> "It is the intent of the Legislature that the DHS develop and submit a corrective action plan to the DOF Office of State Audits and Evaluations and to the Legislature that identifies the actions it plans to take toward implementing the recommendations described in the report entitled, "Final Audit Report—Examination of the Department of Health Services Fiscal Intermediary Contract with Electronic Data Systems for Medi-Cal Claims Processing." **It is also the intent of the Legislature that on October 1, 2004, and April 1, 2005, that DHS submit semiannual reports to the Office of State Audits and Evaluations and to the Legislature regarding its progress towards implementation of the audit recommendations.** The legislative reports shall be provided in writing to the Chairs of all of the fiscal committees of both houses of the Legislature.

Subcommittee Staff Comment and Recommendation: Subcommittee staff **concurs with the LAO recommendation for Supplement Report Language.**

In addition, it is recommended to reduce the Medi-Cal Fiscal Intermediary appropriation by $100,000 (total funds) to delete an augmentation for "unspecified change orders", and to reduce the Medi-Cal Dental Fiscal Intermediary appropriation by $50,000 (total funds) to delete an augmentation for "unspecified change orders". Though it is recognized that these two items are "placeholders" in case issues emerge that need information systems changes, it is not necessary to budget for them now when there is no specificity as to what is needed. Changes can be made through other means, such as a deficiency letter, revised budget, and related mechanisms, once the true need is identified.

Subcommittee Request and Questions: The Subcommittee has requested the LAO and DHS to respond to the following questions:

- **1.** DHS, Please **briefly describe** what ***key*** actions have been taken to date, and what key actions are still pending, with respect to responding to the DOF audit?
- **2. LAO, Please briefly discuss the LAO recommendation**.

Budget Issue: Does the Subcommittee want to adopt the LAO language and make the described budget reduction or craft another option?

8. Medi-Cal Anti-Fraud Proposals—ISSUES "A" to "J"

Overall Background—How Much Fraud is There?: Most indicators point to provider fraud as being a larger concern in terms of fiscal impact on the Medi-Cal Program than beneficiary fraud. Provider fraud schemes typically include over-billing, double-billing, billing for services not provided, false claims, and falsification of dignoses to support billing for unnecessary medical services.

In previous testimony the DHS has noted that **there is no accurate estimates using California specific data to calculate the level of fraud.** Estimates vary on the amount of fraud in the national health care system as well. **One national expert has estimated the level of provider fraud in the fee-for-service portion of Medi-Cal to be about 10 percent.** This estimate is consistent with those of the federal General Accounting Office in regard to the pervasiveness of fraud generally in government health care programs.

As noted by the LAO, if the 10 percent estimate is correct, provider fraud in fee-for-service Medi-Cal would total $1.8 billion dollars *($850 million General Fund)* before any savings and cost avoidances achieved by the DHS through its array of antifraud efforts were taken into account.

Overall Background—Recent Legislation: **The state has responded with a significant expansion of its antifraud efforts over the past five years, including considerable policy changes as noted below:**

- **SB 708 (Senate Budget & Fiscal Review Committee)** established the Medi-Cal Fraud Prevention Bureau and appropriated funds for this purpose.
- **AB 1107, Statutes of 1999 (Cedillo)** brought two federal sanctions into state law: withhold and temporary suspension. It also enhanced Medi-Cal Program integrity by expanding the definition of provider in state statutes to include all entities directly or indirectly involved in providing Medi-Cal services. It clarified the definition of fraud and abuse, and specified new requirements to tighten the provider enrollment process, including new application procedures, signed provider agreements, and provider disclosure statements.
- **AB 784, Statutes of 1999 (Romero)**, among other things, gave authority for auditors to look at records of suppliers, and allowed for the assessment of financial penalties in certain circumstances.
- **AB 1098, Statutes of 2000 (Romero)** expanded the definition of a crime from any person who knowingly intends to commit fraud to any person who engages in activities related to defrauding or submitting false information to the Medi-Cal Program. **It also (1)** increases the licensure requirements for laboratories, and specifies certain activities as crimes if they endanger public safety; **(2)** defines a list of crimes that could potentially be committed by Medi-Cal providers, such as criminal profiteering activity; **(3)** requires providers to identify their billing agents and billing agents to register with the DHS; (4) does not allow enrollments of applicants that have been convicted of any felony or misdemeanor involving fraud or abuse in any government program and not allowing an applicant to reapply for three years if their application was denied.
- **SB 1699, Statutes of 2002 (Ortiz)** gave the DHS the authority to suspend providers from all programs administered by the DHS if the provider is suspended or under investigation in any DHS program and to deny enrollment if they are under investigation in any program.

- **SB 857 Statutes of 2003 (Speier)** enacts several changes including **(1)** revises the responsibilities of providers and applicants for participation as providers in Medi-Cal, **(2)** imposes restrictions on providers related to certain drugs, devices and tests, and **(3)** authorizes the Director of Health Services to annually update designated coding systems.

Overall Background—Error Rate Study and Federal Payment Accuracy Measurement (PAM) Pilot: One of the key elements to a successful anti-fraud program as outlined by experts is to be able to measure the extent of fee-for-service provider fraud within Medi-Cal. **The DHS is in the process of conducting two analyses—the Error Rate Study and the Payment Accuracy Measurement (PAM)—to better make this determination.**

Through the Budget Act of 2003, the DHS was provided staff and funding to conduct an Error Rate Study in order to estimate the extent of fraudulent claims through a random sampling process. In Fall 2003, the state was awarded $601,000 in new federal funds to participate in an effort to determine how much of the state's fee-for-service provider payments for health care are not legitimate-—this is the PAM Pilot. **According to the DHS, these two projects will be completed in October/November 2004.**

According to the DHS, the studies are basically the same in that they will be determining Medi-Cal claims that were paid in error, either due to an improperly paid claim or the recipient was not eligible for Medi-Cal. The DHS notes that each of these studies use a statistically valid sample from paid claims between October 1, 2003 and December 31, 2003 but the samples for each of the studies are stratified differently. **The Error Rate Study is stratified to sample Medi-Cal services provided through the fee-for-service system and have a higher potential for fraud. The PAM Pilot is stratified based on the payment. As such, it will be more skewed towards hospital and nursing home reimbursement.**

Overall Background—Estimated Savings and Cost Avoidance (Period from July 1998 to June 2003): Cost avoidance and savings are how the DHS gauges the effectiveness of its antifraud efforts.

Cost avoidance results when potentially fraudulent new providers are prevented from enrolling in Medi-Cal. The DHS estimates that **cost avoidances amounting to $316 million ($158 million General Fund) has been achieved and will increase to $409 million ($204 million General Fund) in 2004-05. Specifically, the DHS notes the following figures for cost avoidance:**

Summary of Cost Avoidance

Type of Anti-Fraud Activity	# of Cases	Cost Avoidance (July 1998 to June 2003) Total Funds
Pre-Enrollment Screening of Medi-Cal Providers	1,254	$492 million
Screening of Medi-Cal Enrollment for Labs	37	$83 million
Medical Examination Request in Managed Care (validity of when a recipient wants to move from Managed Care to fee-for-service.)	15,636	$64 million
TOTAL-Cost Avoidance	16,927	**$639 million**

Savings are deemed to occur when providers already enrolled in Medi-Cal are found to be engaging in abuse or fraud and their activities are stopped. **The DHS projects that savings of $855 million ($428 million General Fund) have actually been achieved as noted in the table below. In addition, the Governor's proposed budget assumes savings of $618.2 million ($309.1 million General Fund) above the savings generated from activities that began before 2003-04.**

Summary of Savings **Type of Anti-Fraud Activity**	**# of Cases**	**Savings (July 1998 to June 2003) (Total Funds)**
With holding payments	1,300	$331 million
Re-Enrollment of Providers	87	$102 million
Special Claims Review	604	$172 million
Review of Laboratories	46	$77 million
Provider Prior Authorization	255	$64 million
Temporary Suspensions of Providers	752	$43 million
Beneficiary Identification Card Replacement	5,562	$36 million
Pre-Check Write	276	$30 million
TOTAL--Savings	8,882	**$855 million**

Overall Background—State Staff for Anti-fraud Efforts (See Hand Out): The DHS' anti-fraud **staff is distributed among several offices and divisions within the department. The Audits and Investigations (A&I) Division serves as the central coordination point for anti-fraud activities.** The A&I Division tracks fraudulent providers and recipients involved in various fraud schemes, gathers referrals of cases for investigation, analyzes data, audits providers, conducts investigations and coordinates activities with other governmental agencies, including the Department of Justice, FBI and others. **Additional anti-fraud staff are distributed across the DHS in as noted below:**

Summary Chart of Positions **Area of DHS**	**Positions Administratively Eliminated (**)**	**Net *Existing* Positions (vacancies)**
Audits & Investigations	-6.0	165.5 (40.5 vacant)
Payment Systems Division	-12.0	116.0(6 vacant)
Office of Legal Services	-9.0	27.0 (5 vacant)
Medi-Cal Fraud Prevention Bureau	-10.0	22.0 (none)
Medi-Cal Policy Division	-1.0	16.0 (6 vacant)
Medi-Cal Managed Care Division	-9.0	16.0 (1 vacant)
Program Support Branch	-1.0	4.2 (2 vacant)
Laboratory Field Services	-6.0	4.0 (none)
Financial Management Branch	-1.0	3.0 (1 vacant)
Primary Care & Family Health	--	3.0 (none)
Information Technology Services	--	3.0 (none)
Personnel Management Branch	-1.0	4.0 (none)
Fiscal Forecasting Branch	-1.0	5.0 (2 vacant)
Office of Public Affairs	-1.0	--
TOTALS	**-58 (**)**	**388.7 positions (63.5 vacant)*** **

(**) This includes positions the Administration eliminated due to (1) vacant for one-year, (2) Control Section 4.1 reduction, (3) re-directed by the DHS for other purposes (5 total positions), and (4) positions were two-year limited-term and allowed to expire (3 total positions). ***The DHS states that 45.5 of the vacant positions are pending personnel approval, 11 are being recruited for and 7 are vacant with no pending action at this time.

Overall Background—Contract Efforts: **The DHS also contracts with three vendors—Electronic Data Systems (EDS), Delta Dental, and MEDSTAT Group.** EDS, the state's fiscal intermediary who processes the Medi-Cal claims, performs anti-fraud functions related to provider review. The EDS contract contains an incentive clause that allows EDS to keep 10 percent of the program savings that it generates through its anti-fraud efforts. Delta Dental, the state's Medi-Cal dental claims and treatment review contractor, maintains a surveillance and utilization review unit to combat dental-related fraud.

Another contractor--The MEDSTAT Group-- has a comprehensive Medi-Cal database which it uses to conduct checks on the existing claims systems and to look for over payments to providers that may be due to fraud.

Overall Background—Governor's Proposed Budget for Anti-Fraud Activities: The budget proposes **nine adjustments related to Medi-Cal anti-fraud activities as follows:**

- ***Hospital (non-contract) Field Audits (Issue "A" below):*** This proposal requests an increase of 41 state auditors for expenditures of $2.4 million General Fund for the positions, with associated savings of $12.4 million ($6.2 million General Fund) in 2004-05. **Therefore a *net* savings of $3.8 million General Fund is assumed in 2004-05.**
- ***Convert Limited-Term Positions to Permanent (Issue "B" below):*** This proposal requests to convert 15 limited-term positions to permanent on-going status for certain anti-fraud activities pertaining to the enrollment and re-enrollment of Medi-Cal providers.
- ***Non-Institutional Provider Audits (Issue "C" below):*** This proposal requests to shift existing positions from the State Controller's Office to the DHS to continue the provision of non-institutional provider audits. **This proposal assumes savings of $600,000 ($300,000 General Fund) from the reduction of six state positions.**
- ***Delay Checkwrites (Issue "D" below):*** Under this proposal, the DHS would delay Medi-Cal checkwrites to providers by one week to allow the DHS to investigate potentially fraudulent claims before checks are issued. This proposal assumes one-time only **savings of $144 million (General Fund) in 2004-05** due to the shift of some Medi-Cal payments to 2005-06.
- ***Contacting Certain Medi-Cal Providers (Issue "E" below):*** Under this proposal the DHS would contact Medi-Cal providers with suspicious billing patterns. **This proposal assumes savings of $2.5 million (General Fund) in 2004-05.**
- ***Confirming Medi-Cal Recipient Services (Issue "F" below):*** Under this proposal the DHS would confirm with recipients through mail or on-site visits that they actually received services and products that Medi-Cal has been billed. **This proposal assumes savings of $1 million (General Fund) in 2004-05.**
- ***Curtailing Assets (Issue "G" below):*** The Governor is proposing trailer bill language to enhance Medi-Cal estate recoveries by closing an existing provision of state law used to prevent the state from recovering assets from estates to help offset the cost of medical care**. This proposal assumes savings of $474,000 ($237,000 General Fund) in 2004-**

05 *and* $4.2 million ($2.1 million General Fund) as yet an unspecified amount in 2005-06.

- ***Restrict Medi-Cal Billing for Certain Neurological Tests (Issue "H" below):*** The Governor is proposing trailer bill language to restrict billing for electromyography and nerve conduction tests to specially trained physicians. **The budget assumes savings of $1.7 million ($850,000 General Fund) in 2004-05 and $2.3 million ($1.1 million General Fund) in 2005-06.**
- ***Develop Counterproof Prescription Pads (Issue "I" below):*** The Governor is proposing trailer bill language to require all prescriptions for Medi-Cal recipients to be written on prescription blanks obtained from printing vendors approved by the state. **No budget year savings are identified for this proposal. However, savings of $14 million ($7 million General Fund) to $28 million ($14 million General Fund) are assumed in 2005-06.**

ISSUE "A"—Non-Contracting Hospital Field Audits & Home Office Audits

Background—Hospital Cost Reports: There are about **440 licensed hospitals in California**. Medi-Cal pays about $3.5 billion (total funds) for **inpatient hospital services** annually of which **20 percent or $700 million (total funds) is paid to "non-contract" hospitals.** ***Non-contract* hospitals** are those who provide inpatient services to Medi-Cal patients but do not operate under a contract with the California Medical Assistance Commission (CMAC).

***All* Acute care hospitals who provide care to Medi-Cal patients are required to file an annual cost report with the DHS.** There are currently 428 cost reports submitted annually for this purpose. **Of the 428 cost reports about 210 are cost reports for non-contract hospitals.** The remaining 218 cost reports are for hospitals that are under contract with the CMAC.

The DHS states that they review 100 percent of the cost reports for all hospitals. However, the DHS contends that they do not have enough staff to do "full scope" field audits. The DHS states that during the performance of full field audits, procedures are performed to test the validity and accuracy of the hospital's allowable costs and billings more extensively than during a limited desk review or limited field review. Audit tests are performed to ensure that hospital records support not only the cost report but also the claims submitted to Electronic Data Systems for processing.

Background—Home Office Information: **According to the DHS, there are 62 large corporate healthcare chains (Home Offices) that own many of California's hospitals.** These home offices are also required to file annual cost reports with the DHS. These cost reports show the total costs of the home offices and how they allocate costs—such as central management and administrative services-- to the individual hospitals they own in California.

The home office costs are not reimbursed to the home office directly but are included by cost accounting and allocation methods in the individual hospital reports. According to the DHS, these methods of accounting and allocation can be manipulated to increase Medi-Cal reimbursement to the individual hospital.

The DHS states that with current resources, they perform primarily limited field/desk audits of the non-contract hospitals and limited field audits of only 13 of the 62 home offices (remaining 49 are accepted as filed without audit).

Governor's Proposed Budget: The budget is requesting **an increase of 41 new audit staff for increased costs of $4.7 million ($2.4 million General Fund), including $531,000 (total funds) for out-of-state travel. The DHS contends that with this additional audit staff they will be able to save $12.4 million ($6.2 million General Fund) in 2004-05, or a *net* savings of $3.8 million General Fund in the budget year.**

It should be noted that the Governor's budget contains a technical error and does not presently reflect the full savings level of $6.2 million General Fund, but instead shows only a savings level of $3.8 million General Fund. After discussion with the DOF, we have been informed that this figure was in error and that the appropriate amount is $6.2 million General Fund.

The DHS contends that 41 new positions are required to perform the additional audit workload to audit all 62 home offices (currently doing 13) and 210 non-contract acute care hospitals. Since 20 of the 62 home offices are located outside of California, out-of-state travel is being requested. The DHS states that typically it takes three to four consecutive two-week trips (6 weeks to two months of time) involving three to four audit staff to conduct a home office audit.

DHS Hiring Plan for Budget Proposal: The Subcommittee requested the DHS to provide a work plan as to **how the DHS would hire staff, train staff and deploy staff. In response to this request, the DHS notes the following (The proposed time lines reflect a relatively problem free process.):**

- The DHS is in the process of completing the Auditor I examination and will have civil service lists for selection by May 2004. Promotional lists are already available.
- Assuming a July 1 approval for hiring of the positions, it would take the DHS about one month (to July 30, 2004) to make job offers and to complete hiring documents.
- It takes about 6 to 8 weeks to receive all necessary approvals for completion of an auditor hiring commitment and to allow for a new hire to report to work. As such, the **DHS assumes the auditors are on board by September 30, 2004.**
- Auditor training would commence as of October 2004.
- **Audits of the "home offices" would be done by senior audit staff and would begin September 2004.**
- **The first audits would be completed and issued as of January 2005.**
- **Savings from the first audits would begin April 2005.** The DHS states that no collection of over payments made to a hospital can begin prior to the 61 day after the audit report is issued. Also, home office audits will not result in identification of over payments because Medi-Cal reimbursement is not paid to the home offices directly.

Legislative Analyst Office Recommendation: In her Analysis, the LAO notes that the DHS **received 161.5 additional new positions** for anti-fraud activities in 2003-04**. Of these new positions, the Administration chose to eliminate some as part of the Control Section 4.1 process (as contained in the Budget Act of 2003). In addition, some of these remaining positions are still being recruited for and are as yet not all filled.**

As such, the LAO believes that it is premature to approve further expansion before the DHS has implemented the sizable expansion approved last year and demonstrate that it can achieve the savings that were to have resulted from these additional positions.

Further, the LAO contends that expansion in this area should also wait until the Error Rate Study is completed that will shed light on which types of anti-fraud activities warrant a greater focus. As noted above under the background discussion, this Error Rate Study will not be completed until November 2004.

Subcommittee Request and Questions: The Subcommittee has requested the DHS and LAO to respond to the following questions:

- **1.** DHS, Please briefly explain the budget proposal and the savings associated with it.
- **2.** LAO, Please present the LAO recommendation.

Budget Issue: Does the Subcommittee **want to adopt or modify the Administration's proposal to hire 41 staff to conduct non-contract hospital audits as specified?**

ISSUE "B"—Convert 15 Limited-Term Positions to Permanent

Background—Budget Act of 2002: The Budget Act of 2002 **included 15 limited-term positions to conduct Medi-Cal provider re-enrollment functions. The re-enrollment of providers has proven to serve as a valuable tool in mitigating Medi-Cal fraud.** Of the 15 positions, nine were allocated to the Payment Systems Division and 6 positions were allocated to the Audits and Investigations Division.

Workload associated with re-enrollment consists of an on-going process of selecting and prescreening providers, conducting background verifications and claims history analysis, reviewing applications for deficiencies, denying continued enrollment of unqualified providers, conducing onsite reviews of providers as needed, conducting other licensing or certification reviews of certain providers, and denying continued enrollment of unqualified providers.

The 15 positions include the following:

Payment Systems Division	Audits & Investigations Division
• 1 Staff Services Manager I	3 Nurse Evaluator IIs
• 6 Staff Services Analysts	2 Health Program Auditor IIIs
• 2 Office Technicians	1 Laboratory Examiner II

Governor's Proposed Budget: The budget **proposes to convert the 15 limited-term positions to permanent status for expenditures of $1.3 million ($464,000 General Fund).** The existing positions are slated to expire as of June 30, 2004.

Subcommittee Staff Comment: No issues have been raised regarding this request.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please provide a **very brief summary** of the request.
- **2.** Please **provide a brief update on existing re-enrollment efforts**, including any concerns about a backlog of providers awaiting re-enrollment.

Budget Issue: Does the Subcommittee **want to adopt this proposal to convert 15 limited-term positions to permanent** in order to continue to perform the re-enrollment of providers into the Medi-Cal Program?

ISSUE "C"—Non-Institutional Medi-Cal Services Provider Audits

Background: Medi-Cal has **about 72,000 unduplicated providers enrolled in the program to provide non-institutional services to Medi-Cal recipients.**

Medi-Cal providers who demonstrate a pattern of suspicious billings are placed on utilization controls or more restrictive administrative sanctions such as withholding the provider's Medi-Cal payments. Providers placed on DHS utilization controls or administrative sanctions may ultimately be barred from participating in the Medi-Cal Program for up to ten years if convicted and in certain cases, indefinitely.

In addition to administrative sanctions the State Controller's Office (SCO) and DHS conduct audits of Medi-Cal services performed by non-institutional providers to quantify inappropriate and/or over billings to the program. **Since the DHS is the "single state agency" responsible for the Medi-Cal Program, the DHS is required to direct the SCO on which audits to perform, review the SCO audit findings and issue the final audit report and recovery demand, and handle the administrative appeals. The DHS notes that these audits are an integral part of the Medi-Cal anti-fraud efforts with an average demand of $573,614 per audit.**

The SCO has conducted audits of non-institutional services to Medi-Cal recipients since the early 1990's. **However, the DHS contends that that utilizing the SCO via an Interagency Agreement process is no longer efficient. The DHS has a multidisciplinary staff of medical professionals and financial auditors, as well as the authority to identify abusive providers, impose administrative sanctions, and issues audits. These actions can be performed concurrently resulting in a more efficient process.**

Governor's Proposed Budget: The **budget proposes to transfer the responsibility for the Medi-Cal non-institutional provider audits currently being conducted by the SCO, through an Interagency Agreement (IA), back to the DHS.** The SCO dedicates 26 positions to the audits conducted under the IA at about $4 million ($2 million General Fund). **With the proposed transfer, the DHS is requesting to fund 20 positions which will result in savings of about $600,000 ($300,000 General Fund) from the reduction of the six positions.**

Subcommittee Staff Comment and LAO Comment: The Subcommittee staff and LAO concur that this transfer makes good policy and fiscal sense. The transfer would better centralize the Medi-Cal anti-fraud audit functions and would reduce state staffing needs by six positions. No issues have been raised.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please describe the proposed transfer and why it would be more efficient.
- **2.** Could many of the existing SCO staff currently performing these functions be hired/transferred to the DHS as well?

Budget Issue: Does the Subcommittee **want to approve the proposal to transfer the non-institutional services audits from the State Controller's Office to the DHS?**

ISSUE "D"—Delay Checkwrites One Week

Background and Governor's Proposed Budget: The Medi-Cal Program provides reimbursement to providers through "checkwrites". Normally there are 52 checkwrites (one per week) per year conducted by the state's fiscal intermediary.

The budget proposes to delay by one week the checkwrites for all Medi-Cal Program providers whose claims are processed by the fiscal intermediary (Electronic Data Systems is the contractor). The DHS contends that this one-week delay will enable the DHS to be more effective in its anti-fraud efforts by allowing the A&I Division to perform a more thorough pre-checkwrite review of claims processed and identified as suspect due to normal billing amounts or trends prior to checks being sent to providers. The DHS states that if claims appear suspicious, the claims from that provider will be suspended for further review and not included in the payment process.

The budget assumes savings of $286.6 million ($143.5 million General Fund) by delaying the checkwrite because there will be only 51 checkwrites in 2004-05 instead of 52. The DHS states that this would be a **one-time only budget year savings** because subsequent years would have the normal 52 checkwrites per year. **However, the budget does *not* reflect any savings associated with the DHS identifying savings from their claims review and suspension process. The savings are solely attributable to shifting the checkwrite.**

Subcommittee Staff Recommendation: Based on information regarding savings achieved from the DHS claims review and suspension process, **it is recommended to reduce the Governor's budget by *an additional* $2 million ($1 million General Fund) to reflect the intended outcome of having the DHS delay the checkwrite in the first place—to review suspicious claims and have results.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please briefly describe the budget proposal.

Budget Issue: Does the **Subcommittee want to adopt the Subcommittee staff recommendation, adopt the Administration's proposal, or craft another option?**

ISSUE "E"—Provider Feedback Program

Background: The DHS states that experience has shown that Medi-Cal providers can also be victims of fraud and abuse by having their Medi-Cal provider numbers stolen. These stolen numbers are then used to bill Medi-Cal illegally. In addition the DHS notes that a few providers have been found to abuse the Medi-Cal Program until their billing practices are questioned.

Provider number theft or mis-utilization can occur in a number of fraud schemes as noted below:

- The provider number is stolen with the checks being sent to a new address.
- The billing service for a provider submits additional claims above and beyond the patients that the physician is seeing.
- A new provider within a group receives payment for services but does not realize that their individual provider number is being billed for additional services never performed.

In an attempt to address provider number theft, **the DHS sent about 500 Internal Revenue Services (IRS) 1099 Forms last fiscal year to the home addresses of Medi-Cal providers.** These 500 providers were selected based on a number of factors, such as billing patterns, total billings, and geographic location. **The DHS states that while this pilot did not result in the identification of any identity theft, it did result in these same physicians billing the Medi-Cal Program $5 million (total funds) less over the last 12 months.**

Governor's Proposed Budget: The budget proposes **savings of $5 million ($2.5 million General Fund) by implementing a Provider Feedback Program as of July 1, 2004.** Under this proposal the DHS would send out mid-year Internal Revenue Services (IRS) 1099 Forms to selected Medi-Cal providers at their home addresses. Utilization and billing profiles would also be developed and providers would be notified if their profiles are significantly different than those of their peers. These actions are expected to reduce provider billings as noted. **No additional administrative support is being requested for this proposal.**

This proposed action would be done administratively (i.e., no trailer bill language is proposed).

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following question:

- **1. DHS, Please briefly describe the proposal.**

Budget Issue: Does the **Subcommittee want to adopt the Governor's proposal or craft another option?**

ISSUE "F"—Medi-Cal Recipient "Confirmation" of Services

Background: The DHS conducted two pilot projects—one focused on the distribution of nutritional products to Medi-Cal recipients, and the other focused on the distribution of certain OB products like breast pumps. Under these two pilot projects, the DHS sent out letters to the recipients of these particular products and asked them to respond to questions about whether they needed the products in question and whether they received the products.

From the survey responses the DHS received back on the first pilot, it was found that 9 cases of potential provider fraud needed to be investigated regarding nutritional products because the Medi-Cal recipients did not actually receive the products that were billed by the provider. In another situation, 13 providers are being investigated for potential fraud regarding breast pumps. In addition, it was also found that some providers are now sending out less product overall.

Governor's Proposed Budget: The budget **proposes savings of $2 million ($1 million General Fund)** by instituting two methods (i.e., random and focused) of verifying that Medi-Cal recipients actually received the services that providers billed to Medi-Cal for reimbursement. **These two methods of verification would be to:**

- **Contact a random sample of Medi-Cal recipients by telephone or mail** and **inquire to see if they did indeed receive the medical services**, medical supplies or medical products that were specified; and
- **Contact a Medi-Cal recipient in person or by mail when a review of the provider's billing patterns and diagnosis for the recipient does not appear to match.**

The DHS states that they would work with the state's Medi-Cal fiscal intermediary (EDS) to conduct provider reimbursement and clinical analyses to determine the claims to be verified by the Medi-Cal recipient. Where applicable, the EDS would either (1) send out a "verification" letter to Medi-Cal recipients asking them if they indeed did receive the medical service or product, or (2) contact the Medi-Cal recipient by telephone.

This proposed action would be done administratively (i.e., no trailer bill language is proposed).

Subcommittee Request and Questions: The Subcommittee has requested for the DHS to respond to the following question:

- 1. DHS, Please provide a brief description of the budget proposal.

Budget Issue: Does the **Subcommittee want to adopt the Governor's proposal or craft another option?**

ISSUE "G"—Curtailing Assets and Third Party Payment *(See Hand Out)*

Background and Governor's Proposed Budget: Recently enacted legislation—SB 620 (Scott), Statutes of 2003, placed restrictions on the marketing of annuities to persons age 65 or older if the purpose is to affect Medi-Cal eligibility.

The Governor is proposing trailer bill language that would place additional restraints on (1) the transfer of assets to qualify for Medi-Cal, (2) the sheltering of assets of otherwise resource ineligible individuals, and (3) the sale of annuities to individuals who are receiving personal care, in-home supportive services, or institutional care. The DHS would be given the authority to implement these changes through the use of "all county letters" sent to the County Welfare Directors. The DHS contends that these changes would bring state statute into compliance with federal law (i.e., the federal Omnibus Budget Reconciliation Act of 1993).

Specifically the Administration's proposed changes would, among other things, address the following items:

- Financial transfers of both the individual living in an institution (nursing home, developmental center, ICF-DD facility and others) and their spouse would be scrutinized;
- The "look-back" period would be extended from 30 months to 36 months and in cases involving trusts it would be 60 months.
- Financial transfers would only be permitted as specifically allowed in federal guidelines and the home is not considered an exempt asset for this purpose. Consequently, the transfer of a home is not a protected event, unless it is made to an individual as described in federal law.
- Requires that annuities, if purchased, be purchased for income rather than as shelters. The purchase price of annuities would be considered a transfer of assets and subject to penalty unless the individual gets equal monthly payments for a number of years less than or equal to life expectancy based on federal CMS tables.
- The purchase price of non-commercial annuities and loans will be considered transfers of assets subject to penalty unless secured by an equal amount of real property.
- DHS would be provided with the authority to recover against annuities, annuity payments or distributions received by any person or entity by reason of distribution, survival or designation as part of a deceased Medi-Cal recipient's estate.
- Prevents the transfer of an individual's interest in a settlement or judgement into a special needs trust before the award is actually made to avoid payment of the Medi-Cal lien.
- Requires that the Director of Health Services be notified whenever assets are added to a special needs trust, that if assets are added to a trust established with the assets of a disabled individual after the individual reaches the age of 65 years, then the added assets are not entitled to exception for disabled individuals with special needs trusts, although the total amount of assets retained by the trust shall still be subject to recovery by the Director for medical assistance provided.

The budget assumes savings of $475,000 ($237,000 General Fund) in 2004-05 and $4.2 million ($2.1 million General Fund) in 2005-06. The DHS states that these savings figures are based on a study of 431 cases in three counties. This study found that case records showed that only 1 percent of cases would be impacted by implementation of the curtailment of asset shelter provisions.

It should be noted that the Department of Developmental Services (DDS) believes that this proposed DHS trailer bill language will have little or no impact on residents living at the state's Developmental Centers.

With respect to consumers with special needs living in the community who are receiving Regional Center services and have special needs trusts, the DDS notes that though they do not have actual data on these individuals, they believe that the numbers are relatively small.

Subcommittee Staff Comment and Recommendation: Subcommittee staff believes the proposed trailer bill has merit. However, due to the complexities of law in this area and the over arching policy issues, **it is recommended for the Subcommittee to adopt the proposed savings level but to refer the actual language to the policy committee process for review and discussion.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following question:

- **1. Please describe the proposed trailer bill language and budget proposal.**

Budget Issue: Does the Subcommittee want to adopt the Subcommittee staff recommendation, or adopt or modify the Governor's proposed trailer bill language to curtail assets as described within the Medi-Cal Program?

ISSUE "H"—Restrict Medi-Cal Billing for Certain Neurological Tests
(See Hand Out)

Background and Governor's Proposed Budget: According to the DHS, currently any physician regardless of their specialty can bill Medi-Cal for electromyography and nerve conduction tests. Annual expenditures for these tests are about $3.2 million (total funds). The DHS contends there has been a considerable amount of fraud and abuse identified in the billing of these tests. This has not only created billings to the program that were inappropriate but also has resulted in substandard quality of care to some patients.

The Governor's budget proposes to restrict the Medi-Cal billing of these services as of October 1, 2004 to (1) neurologists, (2) physicians trained in physical medicine or rehabilitation, or (3) other physicians who have received specialized training in electromyography and nerve conduction tests.

The budget assumes savings of $1.3 million ($652,000 General Fund) from this action in 2004-05 and $2.3 million ($1.1 million General Fund) in 2005-06. The DHS expects annual expenditures to be reduced by almost 70 percent.

Specifically under the DHS proposal, physicians would be required to submit certification documents to the department and the claims processing system would need to be updated to allow payments to be made only to certified physicians.

This proposed action requires trailer bill language.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following question:

- **1.** Please provide a brief description of the trailer bill language and budget proposal.

Budget Issue: Does the **Subcommittee want to adopt or modify the proposed trailer bill language to restrict Medi-Cal billing for certain neurological tests as specified?**

ISSUE "I"-- Develop Counterproof Prescription Pads *(See Hand Out)*

Background and Governor's Proposed Budget: The budget **proposes trailer bill legislation to require all Medi-Cal Program prescriptions to be written on prescription blanks obtained from printing vendors approved by the state. The prescription blanks would be uniform, non-reproducible, non-erasable, and numbered. Once the prescriber writes on the prescription it could not be altered in any manner.**

No budget year savings are identified under this proposal because the DHS contends that it will take some time to proceed with actual implementation. Specifically, the DHS states that it would take time to **(1)** secure a vendor for the special prescription pads, **(2)** coordinate with the California Department of Justice (with their implementation of SB 151 (Burton), Statutes of 2003 regarding special substances and the use of counterfeit-proof prescription pads by January 1, 2005), and **(3)** train Medi-Cal providers on the use of the prescription pads. The Administration states that no new staffing costs are associated with this proposal.

The DHS notes that a few other states—New Jersey, Indiana and Florida—utilize a similar counterfeit-proof prescription pad system. New York is working to implement a secured prescription system for certain abused drugs only.

The Administration states that savings of from $14 million (total funds) to $28 million (total funds) could be achieved in 2005-06 from this effort.

Subcommittee Staff Comment and Recommendation: Subcommittee staff believes the proposal has merit as an anti-fraud approach and would save the state General Fund expenditures in 2005-06. **However since the proposal has no budget year implications, it is recommended to direct the Administration to identify a policy bill and author to proceed through the policy committee process.** There is ample time left in the legislative calendar to proceed in this direction and passage of legislation after the budget deadline of July 1 would not have any material affect on this proposal due to the implementation timeframes. The DHS can proceed with working on the various aspects of the proposal prior to passage of the legislation if so desired by the Administration.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following question:

- **1.** Please briefly describe the trailer bill language and budget proposal.

ISSUE "J"—Report Owed to the Legislature on Fraud Expansion Efforts

Background and Budget Act of 2003: The Budget Act of 2003 contained Budget Act Language which **required the DHS to report to the Legislature effective February 1, 2004 and semiannually thereafter regarding the results of the additional 161.5 positions established under the 2003 Medi-Cal Anti-Fraud Initiative.** The report is to include the results of the error rate study and random claim sampling process, the number of positions filled by division and for each of the components of the initiative, the amount of savings and cost avoidance achieved and estimated, the number or providers sanctioned, and the number of claims and beneficiary records reviewed. **This report, or relevant component pieces of the data as noted, has yet to have been received.**

Governor's Proposed Budget: The Administration did include the same reporting language in the Budget Bill for 2004.

Subcommittee Request and Questions: The Subcommittee has requested for the DHS to respond to the following questions.

- **1.** When will the requested information be provided to the Legislature?
- **2.** Since the error rate study will not be available until October 2004, **should a separate reporting requirement be provided for this aspect of the information**?

9. Request for State Staff—Treatment Authorization Requests (TARs) *(See Hand Out)*

Background—What are TARs?: Medi-Cal requires providers to obtain prior authorization for specific medical procedures and services before Medi-Cal reimbursement can be approved. **Generally the purpose of any prior authorization system is as follows:**

- ***Assists in Reviewing Medical Necessity:*** Ensures that patients receive appropriate medical care in a timely manner and that patients do not receive inappropriate treatment.
- ***Assists in Cost Control:*** Mitigates the potential for over utilization of services and serves to direct treatment to facilities with contracted/approved rates.
- ***Assists in Fraud Detection:*** Minimizes the potential for fraud by monitoring providers requesting an unusual quantity of services and patients receiving unusual services.

How Are TARs Processed?: **To file a TAR, providers must fill out one of several types of TAR forms (paper, not electronic) and forward the TAR, usually by mail, to the appropriate DHS TAR office** (six Medi-Cal Field Offices and two Pharmacy Sections). **The DHS then processes the TAR to either (1) approve, (2) modify—such as quantity of service, (3) defer—returned to provider for more information, or (4) deny the request.**

As noted by the California Healthcare Foundation (CHF) in their comprehensive July 2003 report—*Medi-Cal Treatment Authorizations and Claims Processing: Improving Efficiency and Access to Care*— Medi-Cal *takes longer* than other organizations to process TARs. The CHF noted that most of the health organizations they surveyed use the National Committee on Quality Assurance (NCQA) standard of two days turnaround time. In comparison, processing time at Medi-Cal Field Offices averages between 9 and 12 working days, excluding mail-in, mail-out, and mailroom processing time.

Other CHF Report Concerns Regarding the TAR Process: The **CHF report also noted** the following **primary concerns in their analysis:**

- The DHS uses a relatively larger staff than private health plans to process TARs. **Currently the DHS utilizes about 649 positions, including positions under the EDS contract.**
- **The Medi-Cal TAR process is complex.** Medi-Cal requires extensive documentation substantiating the TAR. For some retroactive hospital inpatient stay TARs, Medi-Cal asks for the entire chart to be photocopied to ascertain medical necessity.
- The **DHS does not conduct routine cost-benefit evaluations to determine if requiring prior authorization for certain services and drugs assist in cost control. In addition it was noted that there are no established routine, integrated TAR and claims management reports making it difficult to conduct any integrated analysis** such as tracking whether an authorization ultimately results in a claim, or understanding the cost-benefit by TAR type or drug.
- **The DHS does not use a standardized adjudication methodology for TAR processing.** Having no formal criteria or guidelines means that medical necessity and quality are impacted due to inconsistency. This also causes increased provider confusion and higher appeal rates.

Key CHF Report Recommendations: The CHF Report provided a comprehensive, concrete set of recommendations. **The following highlights key recommendations:**

- **Develop a comprehensive utilization management program**.
- Align Audits and Investigation Division personnel with local Field Offices that process TARs.
- **Create comprehensive guidelines for TAR adjudication** or use standard utilization management programs like other health care provider organizations do.
- **Reduce the number of services that require TARs.** The DHS should identify services that could be managed in ways other than the TAR process.
- **Develop a specific strategy for the evaluation of pharmacy TARs.**
- **Develop different TAR sampling methodologies for providers.** For example, samples could range from 5 to 100 percent , depending upon the services and the provider's TAR and claim history. Based upon provider TAR adjudication patterns and claim history, the Medi-Cal field office could also develop targeted education for the providers.

Governor's Proposed Budget—Request for 36 New Positions: The DHS is requesting **an increase of $4 million ($1 million General Fund) to hire 36 new state positions to process TARs. The requested positions are as follows:**

- 14 Nurse Evaluators II (12 for utilization review and 2 for appeals and litigation).
- 2 Pharmaceutical Consultant II
- 19 Pharmaceutical Consultant I
- 1 Word Processing Technician

It should be noted that approving this proposed budget request would bring the total budget for TAR reviews to about $70 million ($20 million General Fund) and the total staffing level to 685 positions.

The DHS contends that these 36 additional positions are needed in order to keep abreast of the TAR workload. They state that TAR processing has increased by 17 percent from calendar year 2001 to 2002. **In addition they note that this workload level was determined using a formula-driven staffing standards study** (**developed in 1995**).

The DHS is also proposing trailer bill language as part of their budget package; this is discussed below.

DHS Proposed Trailer Bill Language: **The DHS is also proposing trailer bill legislation which would give the department authority to determine the requisite level of TAR reviews for certain TARs or TAR types with high approval rates (i.e., implement a sampling methodology), *without* the need for filing state regulations.**

According to the DHS, this sampling methodology cannot be implemented sooner than July 1, 2005 because they have to select either EDS or another vendor to design, develop and conduct testing to implement an electronic system at the *front end* of the TAR processing.

The DHS notes that their proposal is not to randomly select and automatically approve a certain number of TARs but instead, their proposal is to identify TARs that have a high approval rate and/or low cost and automatically approve them all.

The criterion could change from month-to-month or day-to-day, depending on staff analysis and workload backlogs in the Field Offices. The TARs or TAR types to be sampled is contingent upon conducting a detailed analysis of TAR volume, workload, and savings associated with denials of particular TARs or TAR types.

Legislative Analyst's Office Recommendation: In her Analysis, **the LAO recommends to reject the Governor's request for 36 additional positions, for savings of $4 million ($1 million General Fund)**, because their analysis shows that **increasing the number of staff who process TARs is *not* the most cost-effective way to address the growth in TAR volume.**

They note that the DHS should take steps to reduce TAR workload and believe that the Administration's proposed trailer bill (TAR sampling) is a constructive first step. As such, they recommend approval of the language.

The LAO also notes that the DHS has not yet implemented an internet-based system called Service Utilization Review Guidance and Evaluation (SURGE). SURGE is intended to facilitate faster TAR decisions and processing but it was not yet up and operational. **The LAO believes that such a system would eventually lead to an overall need for state DHS staff in this area.**

Constituency Comments: Generally, **Medi-Cal providers are dissatisfied and frustrated with the TAR process** which they contend results in financial risk to providers and medical risk to Medi-Cal recipients. Various provider groups have been meeting to discuss suggestions for improving the TAR process. **Key suggestions from this process include the following:**

- **Reduce the number of services that require TARs.** It is suggested to use treatment plans and other industry standards to designate diagnoses and procedures as TAR-free (examples cited included Solucient, Ingenix, MedPAR and others). If fraud is an issue for some services, it is further suggested to develop and run sophisticated claims algorithms to identify fraudulent behavior before payments are made rather than utilizing TARs to identify fraud and abuse. **This is similar to the CHF report suggestion.**
- **Reduce the number of TARs processed by the DHS.** It is suggested for the DHS to use a random, statistically significant sampling methodology in lieu of processing every TAR received. This approach would be similar to the proposed DHS trailer bill language.
- **Develop a standard set of adjudication guidelines and publish common instructions for both Field Office staff and providers so that everyone is operating off the same set of expectations.**

In addition to these suggestions, numerous suggestions were offered regarding specific service areas, such as reforms related to TAR processing regarding long-term care, durable medical equipment services, home health and others.

Subcommittee Staff Recommendation: Subcommittee staff concurs with the LAO recommendation **to deny the budget request for 36 new positions for savings of $4 million ($1 million General Fund).** The TAR system is very antiquated and needs substantive change. The sampling approach is a modest step towards improvement **but additional changes as noted in the CHF report and from constituents, should also be considered.** As such, changes to the proposed trailer bill are outlined below.

With respect to the **proposed trailer bill language, the following changes are proposed as noted (differences noted in strikeout and underline)**.

Section 14133.01 **is added** to the Welfare and Institutions Code:

(a) Notwithstanding any other provision of law, the director or his or her designee may apply prior authorization by designing a sampling methodology that will result in a generally acceptable audit standard for approval of a treatment authorization request (TAR), or a class of TARs. The director or his or her designee shall determine the applicable sampling methodology~~.~~ based upon health care industry standards and discussions with applicable Medi-Cal providers or their representatives. This sampling methodology shall be implemented by no later than July 1, 2005, and an outline of it shall be provided to the fiscal and policy committees of both houses of the Legislature. It is the intent of the Legislature for the department to review the sampling methodology on an ongoing basis and updated it as applicable on a periodic basis in order to keep abreast of health care industry trends and the need to manage an efficient and effective Medi-Cal Program.

(b) The department shall pursue additional means to improve and streamline the treatment authorization request process including, where applicable, those identified by independent analyses such as the July 2003 report by the California Healthcare Foundation entitled Medi-Cal Treatment Authorizations and Claims Processing: Improving Efficiency and Access to Care, and those identified by Medi-Cal providers. It is the Legislature's intent that any identified improvements be cost-beneficial to the state and to the Medi-Cal Program as a whole.

(~~b~~) (c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific, this section by means of all-county letters, provider bulletins, or similar instructions. Thereafter, the department may adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

Subcommittee Request and Questions: The Subcommittee **has requested the DHS and LAO to respond to the following questions:**

- **1.** DHS, Please **briefly** describe the budget proposal and proposed trailer bill language.
- **2.** DHS, How is SURGE going to be used with the proposed changes?
- **3.** DHS, Please briefly describe those specific actions taken to improve TAR processing since the release of the July 2003 report.
- **4.** LAO, Please briefly describe your recommendation.

Budget Issue: Does the Subcommittee want to adopt the Subcommittee staff recommendation (same as LAO but with noted trailer bill changes), adopt the Administration's proposal, or craft another solution?

10. Non-Contract Hospital 10 Percent Interim Rate

Background: There are about **440 licensed hospitals in California. Medi-Cal pays about $3.5 billion (total funds) for inpatient hospital services annually of which 20 percent or $700 million (total funds) is paid to "non-contract" hospitals.**

Non-contract **hospitals** are those who provide inpatient services to Medi-Cal patients but do not operate under a contract with the California Medical Assistance Commission (CMAC).

Each non-contract hospital is paid an "interim payment" by the DHS. The interim payment provides payments for services provided through the hospitals' fiscal year. The interim rate, which is what the payment is based upon, is calculated closely to approximate the cost for providing services to Medi-Cal recipients. These costs are then reconciled using hospital cost reports within five months of the end of a hospital's fiscal year. If the costs of providing services is greater than the interim payment, the hospital is reimbursed the difference. If costs are lower, the hospital must reimburse the difference to Medi-Cal. **The DHS states that while there is an attempt to approximate cost with the interim rate, in practice, many hospitals are overpaid during the course of the year.**

Governor's Proposed Budget: The Administration is proposing to reduce interim hospital payments for acute inpatient services by ten percent effective December 1, 2003. **The DHS states that savings of $36.2 million ($18.1 million General Fund) are anticipated for 2003-04, and savings of $62 million ($31 million General Fund) are expected for 2004-05.**

It should be noted that the savings from this proposal may be temporary because audits performed in 2005-06 may reveal that costs exceeded the new reduced interim payments, thus causing additional funds to be paid to the hospitals in 2005-06.

Subcommittee Staff Recommendation: Due to the present fiscal condition of the state, **Subcommittee staff recommends to adopt this budget proposal.** In essence the proposal would temporarily reduce the state's up front expenditure but would ensure that hospitals are paid what they are owed once the final reconciliation is completed.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- Please **briefly describe the budget proposal** and its potential affect on non-contract hospitals.

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